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AUTHOR Peck, David
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ABSTRACT

This research deals primarily with an overview of drug use and/or abuse, with specific discussion of the halfway house concept of treatment, including definition, historical framework, rationales, and inherent problems of halfway houses as modalities of treatment (i.e., economics of the treatment modality). Other special treatment modalities are investigated: civil commitment, parole, guided group interaction, with empirical research examples presented regarding all three. Implications for the various modalities are presented and the general future (s), if any, for the modalities are discussed. (Author)

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"DRUG ABUSE TREATMENT: THE HALFWAY HOUSE AND OTHER SPECIALLY SUPERVISED MODALITIES"

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by: David Peck
Washington State U.
Dept. of Sociology

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I
Overview of Drug Scene

This paper will be an attempt to contribute some simplicity to some admittedly complex subjects: drug use, abuse, and addiction. It will concentrate on the problem of heroin addiction, but will also include comments on abuse of other drugs. Treatment has centered, at least as far as the Halfway House is concerned, on drug addiction. Before any discussion on the Halfway House, drug abuse, and drug addiction is undertaken, one should examine the overall drug "scene", and some consequences from it.

From 1961-68 the number of arrests for drug-related offenses increased by more than 300%.[1] Arrests of juvenile drug users increased by 1,860%.[1] Arrest for marijuana law violations in 1968 totaled 80,000, and they increased ten-fold between 1963-68.[1] Pot smoking is so widespread that there are roughly 25 times as many users as there are places to hold them in all the nation's prisons. In California during 1968, approximately one-fourth of all felony complaints were for violations of marijuana laws. However, both the percentage of those who are convicted, and incarcerated, has declined.[1]

With all the furor over the draft and the war in Vietnam it appears that there are far more youngsters volunteering for drug addiction than there are volunteers for the service of their country.[2] The notion that heroin addiction is caused by poverty, slums, affluence, or youthful disillusionment with America, is an explanation used with less and less frequency.

Much of the adolescent fascination with the drug sub-culture seems to be imitative. The "herd instinct" seems to exist among the young.[2] The question, "Why are you taking heroin?" is usually answered with a shrug and a reference to someone else, or something about "the rest of the guys were using it," The problem is further complicated by a feeling among the young that they are indestructible, that they will not become addicted or that even if they do, heroin is no more serious than marijuana.[2]

Because marijuana smoking and selling is a criminal offense, otherwise "normal" people look at police as an enemy to be feared and hated. It also leads to a credibility gap between the authorities and young drug users. The youthful offenders may have used grass for years and they do not feel any adverse affects nor do they see any among their pot-smoking peers. This often leads them to believe that they cannot believe what the authorities are saying. Consequently, they may try drugs that can cause them great harm because they will not believe warnings, perhaps because it is phrased as a warning.

Police often arrest addicts on sight for the purpose of obtaining information. The policy of police harrassment of drug users is often extremely injurious and demoralizing in its effects upon the addicts. This policy is commonly known as "murder on the installment plan."[1] However, the "physician addict", for example, and contrast, is often treated by the law and narcotics division, and the police with more consideration and gentleness, in marked contrast to the way the socially

handicapped are used by the law and police. When the addict is a "well-to-do" professional man, prosecutors, police, and judges alike are especially strongly inclined to regard him as an "unfortunate" or as a "victim" of something like a disease. Common justifications offered for this practice are that these addicted nurses and doctors do not resort to serious crimes to obtain drugs and they are "valuable and productive members of the community." (But drugs are more easily available to them also.)

Extreme jail sentences and short term jail sentences only seem to alienate those caught because they realize they are only a symbolic scapegoat of those few users who get caught. Another and maybe even more serious hazard of this unjust law is the lack of faith and trust in law enforcement officials and the legislative system. If this punishment and/or compulsive treatment is to be applied, it should be applied equally.[1] This distortion of punishment in relation to actual severity of crime has probably "driven" many young people into a culture of crime. Because these drugs are not legal it forces many young peole to get them from illicit sources, thus leading to more (if any previously existed) contact with the underworld "characters" and gaining nor disrespect for the law.[1] Perhaps because of the past inability (and present?) of the legal system to deal with drug problems, such ideas as the halfway house have risen.

II
Overview & Definition Of The Halfway House Concept

Return to the community may be therapeutic or traumatic. It does not take long for the "mantle" of institutionalization to envelop an individual, and stifle any existence that did exist. A regimented enviroment protects him against the conflicts and struggles of the outside world, but then one is often ill-prepared to cope with it. On returning to the community a drug user is faced with problems involving social, vocational, and psychological rehabilitation.

In one sense, the term "halfway house" defines itself. Many definitions suggest that the halfway house is a transitional living facility, intermediate between institution and community. The descriptions imply a single direction of movement: serving the ex-patient moving "from" the institution to the community. The brochures, pamphlets, etc. of various facilities show a striking and recurrent use of the terms "bridge" and "transition." Micro-analysis of particular "institutions" are needed, in deference to surveys.[3] Vague statements of general goals and idealized versions of administrative procedures can "mask" actualities of daily experience. The survey is only useful because of the wide variety among the "houses, clinics, etc."[3]

Halfway house often refers to any relatively small facility, either residential or non-residential, usually located in or close by a town.[4] Persons involved in the programs of such places

participate in the daily life of the open community, either working, or going to school "outside", or merely as neighbors at times. Devoid of the customary security provisions, a halfway house may be publicly or privately supported, be psychotherapeutically oriented or reality-based, and/or derived from religious, or secular auspices. Persons who live under its comparatively free conditions are expected to undergo a group experience of limited duration. The halfway house stands, perhaps literally, halfway between the community and the institutions (of any sort) as well as those received from the courts.[4]

From the abundance of material descriptive of halfway houses, and out of their seemingly infinite variety of approaches and programs, a "core" of basic elements characteristic of the halfway house concept can be extracted.[4] First, halfway houses are organizationally related to corrections and/or rehabilitation, either as a result of a court order or the administrative action of some public agency. Second, the halfway house idea perhaps necessarily connotes a group situation. Third, it is usually small in size, both absolutely as well as relative to the size of hospitals, penal institutions, etc. Fourth, contact with the community is sometimes important and/or influential. Fifth, the "trappings" of a larege institution, correctional or otherwise, such as walls, fences, locked doors, etc. and are by and large absent. Sixth, some rules and regulations however minimal assure some order and give structure to the living situation. Last, despite varying lengths of time spent in a

Halfway house, the basic aim is to provide a short, intensive, and transitional experience.

A note should be added here that the above ideas may easily apply to treatments involving special supervision techniques (i.e., the clinic) and not only to the term "halfway houses".

Some questions about the general nature of the halfway house have been raised, and some answers, though certainly not all, may be provided in this paper. For instance, are halfway houses, and should they, be something more than acceptable temporary residential places? If so, what are implications with other social work and community agencies? What categories of people should be offered "trasitional care" and who should be responsible for selection, admission, or rejection? Have we, in fact, produced a new instrument of community care policy, or are we in the process of developing, inadvertently, new "chronic wards" in the community?[5]

History, Rationale, and Inherent Problems Of Halfway Houses

III

History

The first halfway houses were generally in rural settings and were, in a sense, spiritual retreats.[6] The orientation was basically humanistic. They stressed the spiritual benefits to be found in working and cooperatively living. The first halfway houses were started and supported by private religious and/or secular groups.[4] The ways of initiation and the sources of encouragement and backing were many and diverse. In some cases,

interested and highly motivated individuals sought out people and organizations who could supply professional and financial resources. Some houses took personal responsibility for their financing. Very often more than a single organization was involved, and once the house began, other sources of support were very often drawn in.[6] This latter idea is also particularly appropriate yet today.

Since World War II the number of houses has increased, especially as government interest has been expressed in the area of delinquency and drug abuse, the obvious increase in many types of drug use, and also as a result of growing disillusionment over the effectiveness of public training and reform school regimens.[4] There has been a progressively rapid development of halfway houses but it was not until 1954 that the term "halfway house" came into popular usage.[6] The halfway house movement may be said to be in its "infacy" but it has become increasingly clear that it is no passing fad.

The halfway house presents a new approach, reflective of a more enlightened public and professional attitude toward drug users and abusers. Its (the halfway house) existence emphasizes the responsibility of the community for the phenomenon of drug abuse, which usually originates in the community.[4] It accommodates people ranging from the parolee, probationer, delinquent, etc. to the voluntary self-help person. Halfway houses may be classified as "out" and "in", the former for people in the process of leaving the spectrum of the institutional setting, and the

latter for the people in the program primarily under court supervision (usually younger offenders of drug laws).[4] Both emphasize the potential advantages of successful community living.

Rationale

A few rationales for programs such as the halfway house are the following:

The halfway hous milieu, or the rehabilitation house, is part and parcel of the concept which forms the background for a therapeutic community.[7] For some persons, return to the former home and/or immediate family is not desirable. Some persons simply have no place to go. Because of this, many drug users have remained hospitalized too long and perhaps past the point where they could benefit from any rehabilitation program. The halfway house does not merely prolong custodial care, as is frequently said by its critics. The success of the transitional residence is dependent on its homelike atmosphere and its abilities to substiute for family support. The intimate social group, sharing common interests and problems, is often a far cry from the impersonal atmosphere of the large institution.

Drug dependency and abuse may be symptoms displayed emotionally by crippled individuals. Addiction is not the problem, the real problem is lack of realistic attitudes and values which the drug dependent individual undergoes a re-educational process, one that will change his self-attitude and values, the need for drugs will no longer exist as a by-product. The working solution

is a therapeutic community. This is a 24 hour a day living, working, learning situtation which re-educates drug dependent individuals enabling them to become contributing members of the community instead of social parasites.[8] Usually staffed by trained ex-addicts who provide the necessary guidance, direction, and intensive therapy needed for successful maturation of the residents, it is run like a family and responsibilities are shared and residents gain more responsible jobs and privileges as they are earned by consistently displaying attitudes and behavioral changes for the better. The staff members and older residents act as role-models for the newer residents to look up to and pattern themselves after.

Inherent Problems

Some inherent problems involving halfway houses and related techniques deal with the enviroment, admission, and staffing. People may favor a halfway house, but no one wants it next door.[3] The extent of difficulty with the community varies-- from inquiries to swearing-out by an organized neighborhood committee of a court-order to have the house removed, but this is not usual. In initiating relations with the community, administrators have used varying approaches, ranging from a conscious effort to avoid initial contact to an active seeking of contact. Some houses announce their specific purposes before opening--others never discuss it at all, even after the house has been operating for several years, to preserve anonymity of the house. The former method is usually the best, but the choice is not entirely an

arbitrary one. A major determinant is the structure and character of the neighborhood. At one extreme is the rural house, and at the other is the large city. In the latter case it would be very difficult to avoid public confrontation. It is also well to recognize that community fears are not always irrelevant. Also, token verbal support from the professional community is not enough.[3]

Concerning staffing and leadership, all houses must have some certain rules and regulations, but some far less than others.[4] Group living is impossible without certain expectations regarding behavior both inside and outside the house. Negative sanctions are often imposed on adults without some tolerance and flexibility. High failure rates often result from formal regulations. Halfway houses, especially under private auspices often settle for fairly elemental levels of expectations. The higher the level of staff competence, the higher the level of performance which can be obtained by the establishment of meaningful relations between residents and staff. Such goals are more lastingly achieved through informal counseling than through fixed directives.[4]

Criteria for admission to a new halfway house tend to become less so with the passage of time. For instance, some halfway houses originally created for parolees and drug users now also admit young people who are not delinquent, as well as first offenders.[4] Halfway houses set up for probationers usually refuse to accept parolees in the belief that their institutional experience has made them less amenable to care. Residential pro-

grams which are treatment-oriented tend to impose relatively rigid admission criteria, as they are geared to deal with young people who are likely to respond positively to the group treatment programs. Non-residential centers, when centrally located, are more accessible to the drug user, and for the user who is unable to tolerate the more intense atmosphere of a residential center, they can help to reduce the urge to give up and flee the program(s). The halfway house administrations must constantly keep in perspective the social facts of the enviroment and practical realities.

Characteristics Of Addicts

To help understand these various rationales, some characteristics of addicts might be informative. According to Vaillant[10], addicts have extremely poor work histories before addiction, and abstentions are positively associated with employment. As a group, addicts are relatively healthy, but 19% had some kind of psychosomatic illness. Their death rate is about three times that of a control population, but the cause of death is almost unanimously a result of drug use. Addicts have usually been deprived not only in a sociological sense by various minority group memberships, but also by physical loss of parents and being born into a culture different from the one in which their parents were reared. Delinquency often precedes drug use, as does inadequate schooling despite often superior I.Q. Perhaps two-thirds of addicts in their thirties become spontaneously abstinent: they "burn-out".[11] They usually tolerate anxiety

poorly, act out, and often engage in self-destructive behavior without realizing it. Abstinence is correlated with age but also with compulsory supervision.

Cost

A frequently used rationale is cost. If the situation arises, halfway houses can be constructed less than custodial institutions housing similar numbers of persons.[4] Annual operating budgets of some small private halfway houses are as low as $8,000, while government-operated residences may well run twelve times that figure. State-operated programs are usually initiated by the director of correctional services, whose task it is then to obtain the approval and financial support of the executive and legislative branches. County-operated halfway houses have to assume the responsibility for obtaining necessary approval, and if they can enlist the support of citizens' groups the task is often made much easier. To hospitalize a drug addict costs $50 or more a day in private institutions and he is often not rehabilitated.[9] At Gateway houses,[9] for instance, the cost is $10.50 per person per day. Not only is the cost less to the community, but he is rehabilitated and re-educated so he becomes a productive human being.

IV
Treatment Modalities

No one treatment for heroin addiction works in all cases and there are almost as many approaches to the problem as there are experts.

The most accepted means of dealing with drug addicts seems to be through a small, controlled, therapeutic community.[12] These residential communities first detoxify, then attempt to rehabilitate the addict by restructuring his ego and life pattern. They accept only those who have proved their determination to kick the heroin habit, and seek to increase the addict's understanding of himself and his problems, through often brutal group-encounter sessions. The programs in a therapeutic community are long-running, from 18-36 months for an individual. There is no agreement within the medical community as to which of these approaches is best, and there is serious competition for the relatively small amount of money available to combat addiction. Everyone sees everyone else as a threat to his program and while the "experts" are arguing, people are becoming addicted and dying.

The halfway house is an institution committed to change. It undertakes to foster development and change. There is a conscious attempt to provide an atmosphere and set of circumstances conductive to helping a troubled person feel capable and interested enough to renew his activities in the world. At most houses, formal programs of therapy are seperated from house activities.[3] There are two advantages to this: 1) if the therapist is also a staff member, there may be confusion between the requirements of these two roles, for the therapist and the house member, and 2) psychotherapists are one community resource--he has influence and power, especially in referrals.

Conflicts between psychotherapists and halfway houses tend to be fought out with the resident as the battleground.

No two halfway house directors would agree on what they mean by treatment, which in all instances is the expression of the philosophy of the individual director, who determines his own program accordingly.[4] Centers with small budgets make few formal efforts at treatment and rely instead on the creation of a family-like situation and the establishment of healthy relationships between the residents. In the more generously endowed centers, where there may be a clearly formulated notion of treatment, the large number of staff and the strictly professional approach may prevent this family-like situation.

Emphasis may be placed on providing shelter, meals, recreational and social opportunities, job assistance, and an atmosphere of friendly acceptance, or the staff may be concerned with changing the attitudes and values which motivate behavior. For delinquents who are customarily suspicious, hostile, and negative in their outlook toward themselves and the world, the treatment approach seems especially appropriate.[4] Individual and group counseling is done by persons from a wide variety of backgrounds: teachers, custodial officers, psyhcologists, ex-drug-users, etc. Few halfway houses can afford professional services of the one-to-one type on any frequent basis, so informality is the predominate mode of therapy. Adequately trained therapists are not available in anywhere sufficient numbers to meet the demands of halfway house work.[4] Because

delinquent drug users are frequently the end result of severe family disorders, some halfway houses undertake to involve parents in the treatment program, and often employ sanctions to do this.

With these background comments in mind, some current programs will now be examined, and again with the thought in mind that halfway house philosophies and modalities can easily apply to other specially supervised techniques.

Civil Committment

One method may be referred to as "civil committment." This deals with the enactment of laws authorizing or compelling committments of addicts for purposes of treatment.[13] These committments usually take place at some point during a criminal proceeding. They are denominated "civil" because they do not result in penal confinement. Civil committment is generally understood to mean court-ordered confinement in a special treatment facility, followed by release to out-patient status under supervision in the community with provision for final discharge if the patient abstains from drugs for the return to confinement if he relapses.[13] At least four types of civil committment are identified: 1) committment on request of non-criminal addicts; 2) involuntary committment of non-criminal addicts; 3) committment on request or consent of criminal addicts; 4) involuntary committment of criminal addicts. Advantages of this program are: it offers maximum benefits to the individual and minimum risk for society, immediate treatment, there is no stigma of criminal conviction,

the addict is given a choice, criminal cases are suspended pending the outcome of committment. Some disadvantages are: the committment is a subterfuge, becomes the civil equivalent of imprisonment, the addict can avoid trial, there should be some proof that the addict is dangerous to himself or others, the inflexible term of committment, the time limit given to addicts to make their choice, etc. This program has broad public acceptance and perhaps has assumed the properties of a movement. The results are too fragmentary and experience too limited to permit anything but tentative judgments.

Parole

Another somewhat unique modality is "parole." This is not a medical technique, but it is classified as a form of treatment insofar as it is used to overcome a person's dependence on drugs. Several parole projects are in operation. The theory is that a parole agency, with its authority over the addict, is ideally situated to arrange and co-ordinate adjustment in the community.[13] Frequent contact and intensive supervision are necessary. The out-patient phase of the California Rehabilitation Program is a special parole project in method, if not in name. According to Diskind and Klonsky[14], there is a need for authoritative casework because in many instances, the addict cannot be relied upon to initiate or to complete treatment of his own volition, because of low therapeutic motivation and weak ego controls. Traditional therapist-patient attitudes do not alsways apply in addiction.[14] It is also an established therapeutic principle

that one cannot effectively and permanently help a person with fundamental internal problems as long as the patient needs and anxieties are superficially or temporarily alleviated by non-therapeutic means. In treating addiction it is often difficult for the therapist to compete with the drug.[14] In the absence of self-motivation it is thought to be necessary to impose external controls in the hope that eventually these controls will be internalized. Considering that one is dealing with a large group of passive and dependent individuals, firm, dynamic direction is essential. However, it was recognized that drug addiction is a problem of community living and parole was not equipped to meet all the needs of the individual so various community resources were also called upon.

The logic of this method is that by exposing the parolee to daily full-time employment and sonstructive leisure time activities it was hoped that for the first time he might develop new aims and aspirations which would sublimate the previously undesirable drive for drugs.[14] However, it is difficult to identify the variables responsible for abstinence and relapse. There were reversions of parolees who abstained for long periods and prolonged abstention of parolees who reverted shortly after their release on parole. Diskind and Klonsky say that it must be remembered that this method deals with convicted offenders. The community has a right to want some amount of protection. A delicate balance must be achieved toward rehabilitation and also protection of society.

Houses serving probationers often schedule group meetings

with greater frequency and focus attention on the altering of attitudes through group pressure. Such group treatment is known as "guided group interaction." An effective ongoing guided group interaction program can produce a strong group culture which helps guide its members to face realistically their prospects and to demonstrate genuine concern for another. Group solidarity and mutual concern are emphasized.

Guided Group Interaction

From its beginnings in the 1940's, what is known today as guided group interaction has spread to halfway houses, correctional and reform institutions, parole and probation services, public schools, etc. This type of group therapy originated during World War II, by McCorkle and Wolf, who were sociologists in search of an effective way of dealing with military offenders on other than an individual basis.[4] The first halfway house to use this method after the war, derived their control from the group process, instead of reliance on traditional walls, fences, bars, deprivation of privileges, punishment, etc. This approach has been greatly expanded and is found today in at least ten states, in both residential and non-residential facilities. The consensus is that it functions best in facilities for from 20-30 people.

In its inception stages, guided group interaction can be distressing to both adult leader and group member. Four recognized and distinct stages follow one another when a new program is created. Not until these stages evolve will a cohesive social

group characterized by common goals be established. Crucial to success is the personality of the group leader.[4] He must be agreeable to granting considerable decision-making responsibility to his group members. He must aim to conduct open, non-custodial programs uncluttered by institutional conventions, but exert subtle pressures to lead group members to examine critically their previous life styles.

Until an expirit de corps develops among the group, some external controls are needed to induce some measure of conformity. This can be eased as the "culture" begins to form and the group develops its own internal controls.

Meetings are frequent, and constant interaction takes place throughout the day, and group norms and purpose develop, especially when the participants derive from similar social and economic backgrounds, and have a somewhat common drug use history.

The establishment of a positive group culture requires certain pre-conditions, i.e., there must be no take-or-leave-it basis, there is time pressure, intake must be controlled, etc. This method seems more likely to be effective with members of lower socioeconomic groups and less so with drug users from middle-class backgrounds.[4] The group leader may begin to withdraw from his prominent role at the earliest and most graceful opportunity. It is the group rather than the leader which is the chief instrument in producing change. Too constant intervention on the leader's part will only make the group members overly dependent on him and a convenient distraction for evading the real problems.

The use of guided group interaction for drug abuse parolees and/or probationers is feasible where such persons have already been exposed to the intensive treatment phase within a center. Guided group interaction confronts the participants with the "here and now" realities of their lives.[4] Group cohesion is the major factor in enforcing the goal of change. The role of the halfway house staff member is vital in guiding and evaluating the process, and easing tension among the drug users.

Empirical Examples

A number of different houses, programs, etc. will now be examined to give the reader some idea of the variety and complexity of drug abuse treatment modalities.

The Gateway House Foundation[9] is a non-profit Illinois organization which offers a place, a program, a workable solution instead of a stop-gap, to help drug dependent individuals seek a way toward a responsible, useful life in the community. These people represent only those addicted to hard drugs, like heroin and the psychedelic drug abuser who is not an addict, but is using illegal drugs. Gateway Houses help the drug addicts and abuser to grow up, to learn to be responsible adults, teach them, and help them to learn to help themselves.

Archway Houses[15] are houses for drug abusers, and operates with the medical, psychiatric, and financial assitance of the Missouri Institute of Psychiatry. They are broken up into three phases: 1) live in, work in 2) live in, work out, and 3) work out, live out in the greater community. It is constantly in

need of more support, and it is now making an effort to reach the drug abuser in the street and do preventive work, It has attempted to do this through the idea of out-reach centers. Plans for these centers are for juveniles 17 and under and to also work in the field of prevention through speaking engagements at the centers.

The Magdala Foundation in St. Louis[16] is primarily a halfway house for women with criminal records from age 17 and up. However, they do accept women who have a history of drug abuse and/or use, but who are not actively involved in using drugs. It offers out-patient and residence services and <u>all</u> clients are automatically referred to the State of Missouri Division of Vocational Rehabilitation. Among the interesting house rules are that 1) discussion groups have mandatory attendance, and 2) all residents of the house are to stay out of <u>all</u> business establishments in the neighborhood.

At the Zeller Zone Center in Peoria, Ill. there is a treatment program called "Stonehedge."[17] Its basic approach is behavior modification. The staff in this drug program have learned through experience that some of the more salient characteristics of drug dependence are manifested by hedonistic demands placed upon others in the immediate enviroment by the drug user. The goals of this therapy do not include a staff orientation whereby staff competencies and community resources should be abused and exploited in the name of compassion. To do otherwise is to reward addiction. This program is an in-patient modality and entails a hierarchial relationship among the staff members in order that

the staff members cannot be played one against the other, a process for which addicts appear to be notorious. The ultimate goal is for the drug abuser to become drug-free and independent whose life style has been modified to the extent that he can rely on his own resources in everyday life. The rationale is that drug dependence is a symptom of a deeper underlying disorder due to earlier faulty psychological development. The program attempts to strengthen inner controls.

Drug Addict's Recovery Enterprises (DARE) was created in 1971 in Albuquerque, N.M.[18] It is centered around a religious therapy rationale. The live-in faciltiy of DARE is staffed with married couples as supervisors. It provides the residents with necessities of life and medical care while in residence or until they are renewed to a state of self-support and self-sufficiency. The rationale is that it is vitally necessary for the ex-addict to become productive in society for the mutual benefit of both and this can be best done by religious guidance and training. DARE has an "outreach" facility also, which is a youth center orientated to the Bible studies, rap sessions, and street ministery. It is also staffed with married couples. DARE is a non-profit corporation supplemented by a broad group of church and civic associates.

An interesting experiment involving a group of addicts who are attempting to make the psychological break from narcotics, is present at a place known as Daytop Village in New York.[19] Daytop is run by addicts themselves since they are judged to be in the best position for determining what a 'junkie' needs in the

way of discipline and responsibility. Even thogh the addicts are physically separated from drugs and their dependence is no longer a physical requirement. Daytop helps them tear down the psychological barriers that exist between themselves and their ability to handle social problems. Each member at Daytop plays a therapeutic game designed to help discover his psychological reasons for turning to heroin.

The Illinois Drug Abuse Program[20] is at present largely for persons addicted to heroin, although components for young people who abuse other drugs have recently been initiated. This program rejects the view that being drug free must be the sole or even the most important standard for admittance to the program(s). Instead, it holds that in the program to be proposed the minimum expectation would be that all patients become law-abiding citizens--even if they did not become productive, drug-free, and beginning to make some progress toward emotional stability.

In the beginning, the pilot program would develop, use, carefully evaluate, and compare several different modalities. These included: 1) pre-treatment or holding pattern: a dispensary offering no rehabilitation services other than methadone medication, to determine whether medication alone can help the addict; 2) outpatient methadone clinics: they would supply methadone support for an indefinite length of time and weekly group therapy; 3) the in-resident multi-method center: a temporary, but highly structured setting using many modalities including methadone, therapy, education, vocational rehabilitation, etc.; 4) the halfway house: patients from various treatment settings who, after a

period of residential care, have effectively come to grips with their heroin problem. It operates on an out-patient and in-patient basis, there is less emphasis on group therapy, and patients prepare themselves for dealing with ordinary situations (i.e., and employment application); 5) the in-patient, long-term drug-free communities: they emphasize abstinence, restructuring of character, and accept heroin and non-heroin patients. The residents are required to remain drug-free and intensive group therapy is used. Patients stay from one-to-two years; 6) re-entry clinics: they serve heroin addicts who were members of other treatment units and who left either voluntarily or involuntarily, before treatment was completed. Methadone is dispensed and group therapy is mandatory. Social, vocational, and legal services are provided when necessary.

The Lexington and Ft. Worth Public Health Service Hospitals were established in 1935 and '38 respectively for the primary purpose of providing treatment to Federal prisoners who were addicted to narcotic drugs.[13] Voluntary patients are admitted on a space-available basis after Federal prisoners have been accommodated. After detoxification, the services are designed to mainly improve functional skills and to accustom the patient to a stable enviroment. The recommended length of stay for a voluntary patient is five months, but most check out much sooner against medical advice. The hospital authorities are powerless in the community, except in the case of the prisoner-patient who is granted parole.

The California Rehabilitation Center was established in 1961.[13] Most admissions are of addict misdemeanants and felons convicted in California courts and committed by order of the court. It is a combination of in- and out-patient treatment, and the addicts are required to remain on status for at least six months, although the average is close to 15 months. Work therapy, vocational courses, and a fully accredited academic course through high school are offered. Upon release, patients are supervised by caseworkers with special training and small case-loads. Patients are chemically tested for the presence of drugs. Failure of the test or other idication of relapse to drugs results in return to the institution. A halfway house, the Parkway Center, provides guidance for those making a marginal adjustment to the community. The patient becomes eligible for final discharge after three drug-free years as an out-patient.

The New York State Program[13] is for treatment and prevention of addiction. A commission was authorized to conduct basic clinical and statistical research, operate rehabilitation and after-care centers, and to establish a unified program of education, prevention, care and community referral.

Treatment Modalities: Implications, Results, Research
V

Implications

Many halfway houses, particularly those under private auspices, make no attempt to measure the effectiveness of their programs(s).[4] More than one instance has been reported of conflicts

developing between research teams and staff members of halfway houses. On the basis of available research results, no single halfway house program can be rated superior or inferior to any other, not only because they vary, but also because no group of residents is precisely comparable to any other. Intake criteria also differ. With the exception of data from the California Community Treatment Project, virtually all credible research has come from halfway houses which apply guided group interaction procedures, and these findings are contradictory.[4] Efforts to predict recidivism have also led to contradictory results. Attempts have been made to assess attitude changes, but these have also been contradictory.[4] One conclusion which seems to have validity is that the resident halfway house is not necessarily an alternative to standard probation care for drug users.[4] In fact, some users seem clearly unable to adjust to group situations and are better off in other treatment programs.

Results & Research

Diskind and Klonsky[14] report that three follow-up studies were done concerning parole modalities. The first study revealed that 35% made a completely satisfactorily adjustment in that they did not revert to drugs nor did they violate any other conditions of their parole. The more "chances given" to a relapsee, the less was the chance for complete abstention. Older parolees had a higher abstention rate--perhaps due to the maturing factor of to the cycle of addiction itself (the "burn-out"). In the second study of 344 parolees, it was found that 24% made a successful

adjustment. The median length of supervision for these sucessful parolees was 15 months. A third study was initiated concerning sucessful parolees who completed parole to determine if their satisfactory behavior continued after removal of all legal restraints. It was found that 55% continued to refrain from drugs in the post-parole period. Those who relapsed did so within six months, only 31% of these were employed and 95% had had at least one conflict with the law.

Vaillant and Rasor[21] report a study of longitudinal comparison of five treatment methods: 1) voluntary hospitalization; 2) short imprisonment; 3) long imprisonment; and 4) imprisonment and parole; and 5) community follow-up by a social agency capable of providing appropriate referrals. Sixty-seven per cent of treatment defined as imprisonment (long) and parole resulted in community abstinences of a year or more, while only 47% of short imprisonment and hospitalization were followed by abstinences of similar length. The findings also suggested that mandatory sentences neither cure nor deter. In summary, as many addicts as is legally feasible should be under some type of constructive, authoritative control.

Brotman, Meyer, Freedman, and Lieberman[22] suggest that from the community mental health perspective an implication is clear. We will achieve no success in ameliorating the problem we make of addiction so long as we aim our efforts primarily at changing personalities or adaptive patterns of individual addicts while ignoring those aspects of the social enviroment--the community's

ambivalent attitudes and puntive policies. We ought to aim at the criminal and civil laws and the public and private stereotypes that support them. Addictive behavior is significantly affected by public policy.

Some results of the Illinois Drug Abuse Program[20] are: research on out-patients indicate that arrest rates have fallen dramatically, about two-thirds of the out-patients medically able to work are working, and on any given week the unauthorized use of drugs (testing urine specimens) is less than 20% of the total out-patients and less than 10% of all in-patients.

The Washington Heights Rehabilitation Center[23] is a five-year long program in narcotics addiction in which the goal is to learn how a Department of Health can co-operate with a court agency to "mange" the addiction problem in a specific area of New York City. The rationale derives from cumulative experience of various parts of the country that use of compulsion and help in the local community constitute the best known means of rehabilitating addicts. Emphasis is on research and evaluation and study of addicts in their own enviroment. Two primary variables are being investigated: 1) Reaching-out (improving motivation of addicts and "keeping track" of them) and 2) Use of authority (rational authority--providing firm structure to help addicts internalize controls). Other secondary "cues" to be studied are: use of neighborhood-based programs, family-centered approach, crisis-intervention, tolerance of abstinence, and built-in research (primary and secondary).

Brotman, Meyer, and Freedman[24] state that the latest panacea grasped at by the community for somehow solving the problem of addiction is hospital beds. This only diverts attention from the community's responsibility for careful analysis and starting new programs. It is especially appropriate in those conditions for which no cure has been found, to concentrate on reducing dysfunction within the limits set by the chronic nature of the condition. This is unconventional only because it rejects present punitive and moralistic approaches.

Brill[25] states that two major trends may be distinguished in treatment methods: one away from the former exclusive community setting, and second, a diminishing preoccupation with the former goal of total immediate abstinence to that of adequate functioning in the community. We need to stop thinking of simplistic solutions and foster greater involvement on the part of local facilities.

Vaillant[11] states there is little to support the idea that punishment per se either deters or benefits the addict. Probably the authoratative treatment of addiction is beneficial not because it punishes but because it enforces, and meaningfully cares about, certain of the addict's needs--needs to which voluntary programs can only pay "lip service." The addict needs someone to care when he is honest and independent, and neither the family nor most professional workers can effectively provide this control.

VI

Future of the Halfway House and Other Special Supervisions

Despite the inherent difficulties in conducting valid research, the gravity and proportion of our national drug abuse problem continued efforts to assess the value of different rehabilitation programs. Sums appropriated for research have been infinitesimal. Knowledge applicable to one situation cannot always be transferred satisfactorily to another, but exploration in greater depth of the variables associated with good and poor adjustment in various halfway houses under a wide variety of treatment programs must continue to be made. The conclusion should be obvious: if society continues to permit institutions to contain people in accordance with programs which virtually every evaluative study has shown to be productive of a rate of failure of ½ to two-thirds of its "graduates", then the halfway house facility, whether residential or non-residential, should not be held to a higher standard of critical self-examination.[4] For kids on "junk", of all the forms of treatment or temporizing that have been tried, the residential group therapy center seems to provide the strongest support.[12] But most of the U.S. cities have simply no facilities whatever for handling teen-age addicts, even New York City has no funds (public) specifically for treating addicts under 18.

According to Grupp[26], in a study concerning marijuana, it is stated that there has been a decreasingly punitive response to the convicted adult marijuana law violator. While this drug is

not often thought of in rehabilitation terms, it seems to be an acknowledged fact that marijuana smokers are sometimes multiple users, including narcotic drugs. Also, relatively more persons with serious prior criminal records are being released, dismissed, or acquitted.[26] If the punitive response is diminishing, this writer wonders where all of the marijuana smokers who are using other hard drugs go to for hlep? That is, if they want it. It seems to this writer that the halfway house can be of value not only to heroin addicts but also to non-heroin drug users and/or abusers. Interestingly enough the Illinois Drug Abuse Program[20] is experimenting with non-heroin residential treatment units. Further research must be done on the results of these treatment units, but these units are to be run locally and hope to employ many ex-addicts and/or ex-drug abusers (non-heroin) and past multiple drug users. Presumably the halfway house "movement" can play a large part in this experimentation.

Regarding the future of civil committment perhaps Schur's[27] analysis is informative. He says that there is evident indecisiveness in the President's Commission concerning civil committment programs. Schur states that Aronowitz determines that the involuntary committment of non-criminal addicts is an undesirable public policy. Indeed, Aronowitz concludes that "as long as there is no evidence to show that existing methods for treating addicts hold out a reasonalbe prospect of cure, civil committment is but a euphemism for imprisonment."[27] The commission on the other hand, concludes that civil committment (involuntary) offers

sufficient promise to warrant a fair test.[27] So obvious ambivalence and contradiction exist concerning aspects of civil commitment.

As for parole, some comments by Diskind and Klonsky are useful.[14] They state that follow-up studies of parolee addicts were encouraging overall. Even though many parolee addicts were encouraging overall. Even though parolees relapsed, the period of abstinence was at least, in most cases, five or six months. This may prove to the addict that it is possible to get along without drugs for some time and although he might relapse, he will at least realize that voluntary abstention is not an impossiblitity. This factor alone might be significant in rehabilitation. The setting of limits to clients is now universally accepted by the social work profession as an essential ingredient of practice.[14] Since the average addict appears to be unmotivated for treatment, it follows that some programs at least, should embody a degree of compulsion to insure cooperation on part of the client and/or patient. Sanctions and limits are imposed in all modalities. Although the private modality may not arouse images of a threatening authority figure, and their framework provides for greater flexibility, authority is an integral part of the private modality, though not so overtly. It seems to this writer that parole as a supervisory technique with addicts has a long way to go to improve its methods and results, and assumptions. I particularly find somwhat arrogant the assumption that few, if any, addicts are motivated. If this is so, then why are so many able to abstain from drugs for

at least a short time? If they are not motivated, why are they given parole?

Where does the blame belong for drug abuse and addiction? The answer seems to be that it must be shared by everyone to some extent since the drug user is a product of an enviroment we all helped to create. According to Dr. Robert Peterson of the National Institute of Mental Health, "One of the real problems is that drug abuse is such an emotionally loaded issue."[19] This can apply to treatment methods also. Only society can take the initiative in changing this emotionalism of drugs and why people take them.

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